Missouri

Establishing a Diabetes Collaborative to Implement the Chronic Care Model and Monitor Available Health Services

Public Health Problem

Diabetes-related care for high-risk, medically underserved, and racially/ethnically diverse populations must be improved to decrease health disparities and prevent serious diabetes complications. In 2001, an estimated 6.5% of adult Missourians (about 276,453 persons) reported physician-diagnosed diabetes.

Evidence That Prevention Works

Studies have shown that by providing better access to preventive care, diabetes-related outcomes such as blindness, kidney failure, and lower-extremity amputation can be prevented or delayed.

Program Example

The Missouri Diabetes Prevention and Control Program (MDPCP) collaborated with six federally qualified health centers (FQHCs) and one National Health Service site that participated in the Bureau of Primary Health Care's National Health Disparities Diabetes Collaborative. From June 2000 to June 2002, each center implemented the Chronic Care Model in one or more clinics, forming teams of diabetes-related health care specialists. Each center established an initial "population of focus," a registry of patients with diabetes. Additional provider or site registries were added as the project period progressed. The Diabetes Electronic Measurement System (DEMS) was used to monitor indicators of health status, health behaviors, and services received. The MDPCP's second-year evaluation of aggregate data from the combined diabetes registries of the seven Missouri health centers participating in the Diabetes Collaborative found that the number of patients enrolled in the Diabetes Collaborative increased from 1,107 to 3,431, or by 210%. In the aggregate registries, there were significant improvements in the prevalence of 10 key measures: (1) average A1C value (-3%), (2) retinal eye exam (+197%), (3) dental exam or referral (+325%), (4) foot exam (+18%), (5) influenza vaccination or referral (+149%), (6) choleterol testing (+37%), (7) body mass index calculation (+15%), (8) diabetes education (+78%), (9) self-management goal setting (+24%), and (10) nutrition counseling (+92%).

Implications

In Missouri, the health centers' participation in the Midwest Cluster of the National Diabetes Collaborative made and sustained substantial improvements in the quality of care for their patients with diabetes. Future efforts should focus on maintaining and improving these gains while extending their benefits to other Missourians with diabetes. This program demonstrates the importance of team delivery of comprehensive health care and increasing patients' participation in the management of their diabetes.

Contact Information

Missouri Department of Health and Senior Services • Missouri Diabetes Control Program
920 Wildwood Drive • P.O. Box 570 • Jefferson City, Missouri 65102-0570
Phone: (573) 522-2862 • Web site: www.dhss.state.mo.us/diabetes/index.html